

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. This certificate is the property of the State Health Department and should be returned to the State Health Department when requested. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> 01118 Item 7 Film G307 2/13/62 ink 01109 </div>											
1. PLACE OF DEATH a. COUNTY QUEEN ANNE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First WILLIAM Middle BRINSON JR. Last BRINSON JR.						4. DATE OF DEATH Month JAN. Day 10 Year 1962					
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OYSTER SHUCKER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BRINSON						14. MOTHER'S MAIDEN NAME ELIZABETH WHITE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT VERDA FATMAN Address 4925 WALTON AVE. PHILA PA.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old pulmonary tuberculosis and bronchial asthma											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002.2							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE C. R. Layton						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) C. R. Layton, Grasonville Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF JAN. 15		22c. NAME OF CEMETERY OR CREMATORY Church Hill Colored		22d. LOCATION (City, town, or country) (State) Church Hill Md.	
23. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.						24a. REGD. BY REGISTRAR JAN 18 62		24b. REGISTRAR'S SIGNATURE Edgar L. Lane			

01119

CERTIFICATE OF DEATH

Reg. Dist. No.

01110

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>X Church Hill</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Anthony Butler</u>				4. DATE OF DEATH Month Day Year <u>Jan. 20 1862</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1890</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Anthony</u>				14. MOTHER'S MAIDEN NAME <u>Emma Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-0390</u>		17. INFORMANT <u>Mary Griffin</u> Address <u>Queenstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> years							INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> , to <u>1/20</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>62</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 S. Liberty St.</u> DATE SIGNED <u>Jan. 22, 1962</u>							
ACTUAL SIGNATURE <u>C. Rodney Layton</u>				M.D. <u>104 S. Liberty St.</u> Jan. 22, 1962			
PHYSICIAN'S NAME (Type) <u>C. Rodney Layton</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Solan</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01120

01111

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE N. J. b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crumpton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pleasantville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Davis Nursing Home		d. STREET ADDRESS 67X 3	
3. NAME OF DECEASED (Type or print) First Samuel Middle W. Last Curlott		4. DATE OF DEATH Month January Day 25 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower		10b. KIND OF BUSINESS OR INDUSTRY Glass Factory	11. BIRTHPLACE (County & State, or foreign country) Md.
13. FATHER'S NAME William Curlott		14. MOTHER'S MAIDEN NAME Clara Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 157-10-2786	
17. INFORMANT Earl Price,		Address Barelay, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Disturbance 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Chronic myocarditis Chronic Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sincerely		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No	
20c. TIME OF INJURY Hour a.m. 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sudlersville, Md.
21. I certify that (I) (this hospital) attended the deceased from April 1, 1961, to Jan 25, 1962, that (I) (we) last saw the deceased alive on Jan 22, 1962 and that death occurred at 3:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE C. J. White		22b. DATE SIGNED 4/26/62	22c. PHYSICIAN'S NAME (Type) C. J. White
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 28, 1962	23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.		25a. REC'D BY REGISTRAR JAN 29 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. ADDRESS Sudlersville, Md.	

091130

(M)

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

091130

01121

CERTIFICATE OF DEATH

Reg. Dist. No. 01112

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13-1895</u>	9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William James Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Seney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO.		INFORMANT <u>Mrs. Charles Walls--Crumpton</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Chronic myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FD</u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>20</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <u>Dec 21, 1961</u> to <u>Jan 19, 1962</u> that I last saw the deceased alive on <u>Jan 17, 1962</u> and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.H. Metcalfe</u>			ADDRESS (Street, city or town, state) <u>Sudlersville, Md.</u>			DATE SIGNED <u>1/21/62</u>	
PHYSICIAN'S NAME (Type) <u>C.H. Metcalfe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 21</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 25 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>William L. Kramer</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATION 1000000

1877

1000000

1000000

1000000

1
M
X
I
O
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I
O
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01122
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Queen Ann MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maryland	
c. LENGTH OF STAY IN 1b 3 Months		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William L. Faulkner		4. DATE OF DEATH Month 1 Day 30 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1884
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 1 Days 30 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Faulkner		14. MOTHER'S MAIDEN NAME Elizabeth Ware	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert McGinnis Sudlersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Acute Cardiac Dilatation Chronic Hypertension Cor Pulmonale PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) } Smoked INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 7:30		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 30, 1962 to Jan 30, 1962 that (I) (we) last saw the deceased alive on Jan 30, 1962 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE @infitec		22b. DATE SIGNED 2/2/62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Sudlersville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-62	
23c. NAME OF CEMETERY OR CREMATORY Templeville		23d. LOCATION (City, town or county) (State) Templeville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		25a. REC'D BY REGISTRAR FEB 5 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Hume		25c. ADDRESS	

01122

(M)

1

Green Am

Small, slender, 1/2 inch

Long

White

White

Retired, 1900

Little, 1900

10

(Small, slender, 1/2 inch)

White, 1900

White, 1900

White, 1900

White, 1900

White, 1900

White, 1900

White, 1900

White, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01123 Item 9 Film G305 1/26/62 ink 01114

1. PLACE OF DEATH
a. COUNTY Queen Anne MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Centreville
c. LENGTH OF STAY IN IL Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY Queen Anne
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Centreville
d. STREET ADDRESS 1

3. NAME OF DECEASED (Type or print) Addie First Middle Last
4. DATE OF DEATH Jan 16 1962 Month Day Year
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec 17 1896 9. AGE 65 years IF UNDER 1 YEAR IF UNDER 24 HRS.
WIDOWED ☐ DIVORCED ☐ 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Housewife 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LAYMAR GROCE 14. MOTHER'S MAIDEN NAME MARY F. SPARKS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. LOUIS HAWKINS 17. INFORMANT LOUIS HAWKINS - Centreville, Md. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Diabetic Coma
DUE TO Uncontrolled Diabetes
Conditions, if any, which gave rise to immediate cause (b) 363 x
(a), stating the underlying cause last. DUE TO 363 x
(c) 363 x
INTERVAL BETWEEN ONSET AND DEATH 3 days
years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

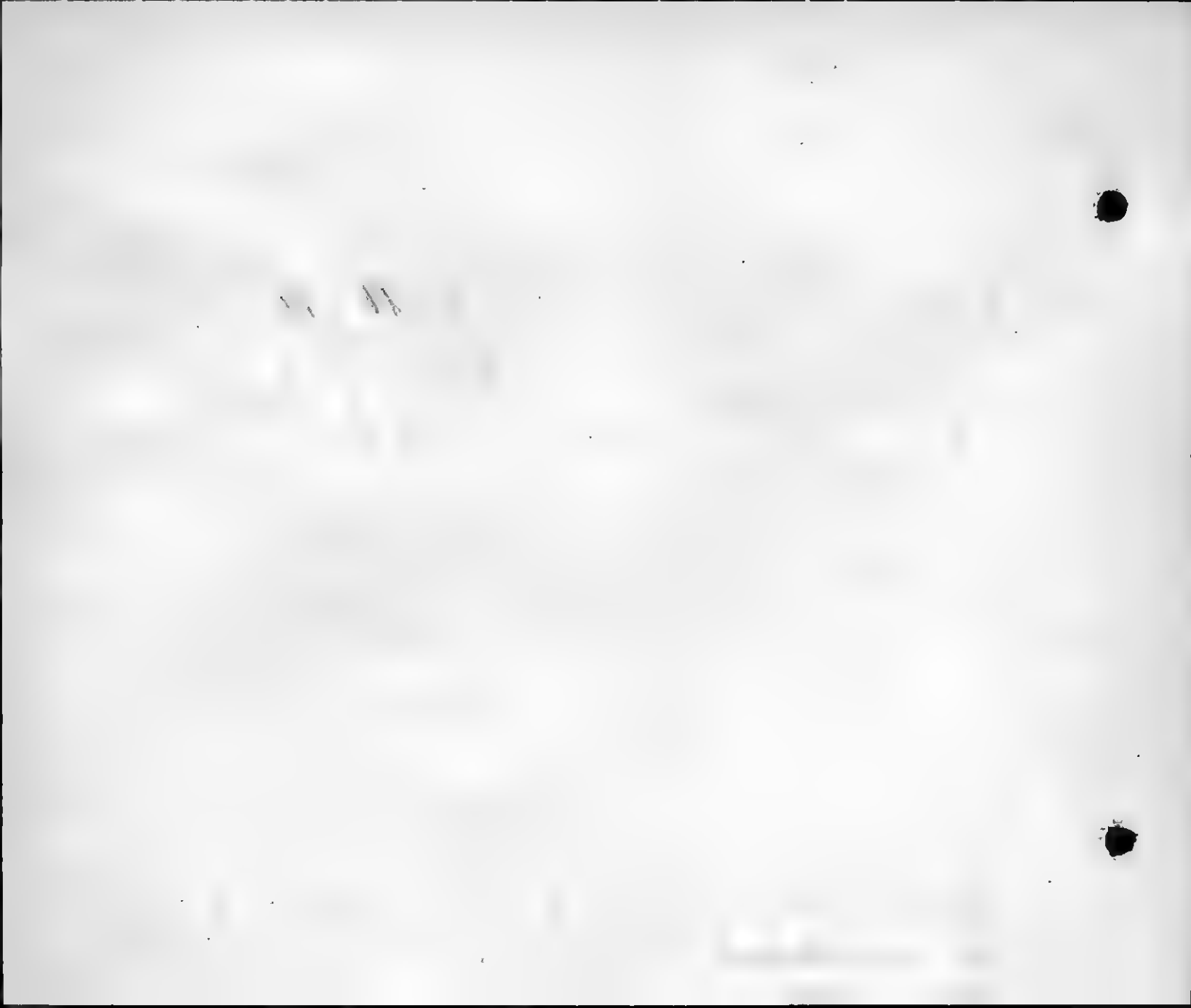
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Jan 15 1962 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 15 1962 to Jan 16 1962, that (I) (we) last saw the deceased alive on Jan 15 1962 and that death occurred at 2:30 PM, from the causes and on the date stated above.

22a. SIGNATURE C. R. Layton M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 1-19-62
22c. PHYSICIAN'S NAME (Type) C. R. Layton 22d. ADDRESS Centreville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1-20-62 23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem. 23d. LOCATION (City, town or county) (State) Centreville Md.

24. FUNERAL DIRECTOR'S SIGNATURE James B. Schell - Easton, Md. ADDRESS Easton, Md. 25a. REC'D BY REGISTRAR JAN 24 '62 25b. REGISTRAR'S SIGNATURE Chas. S. Evans



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

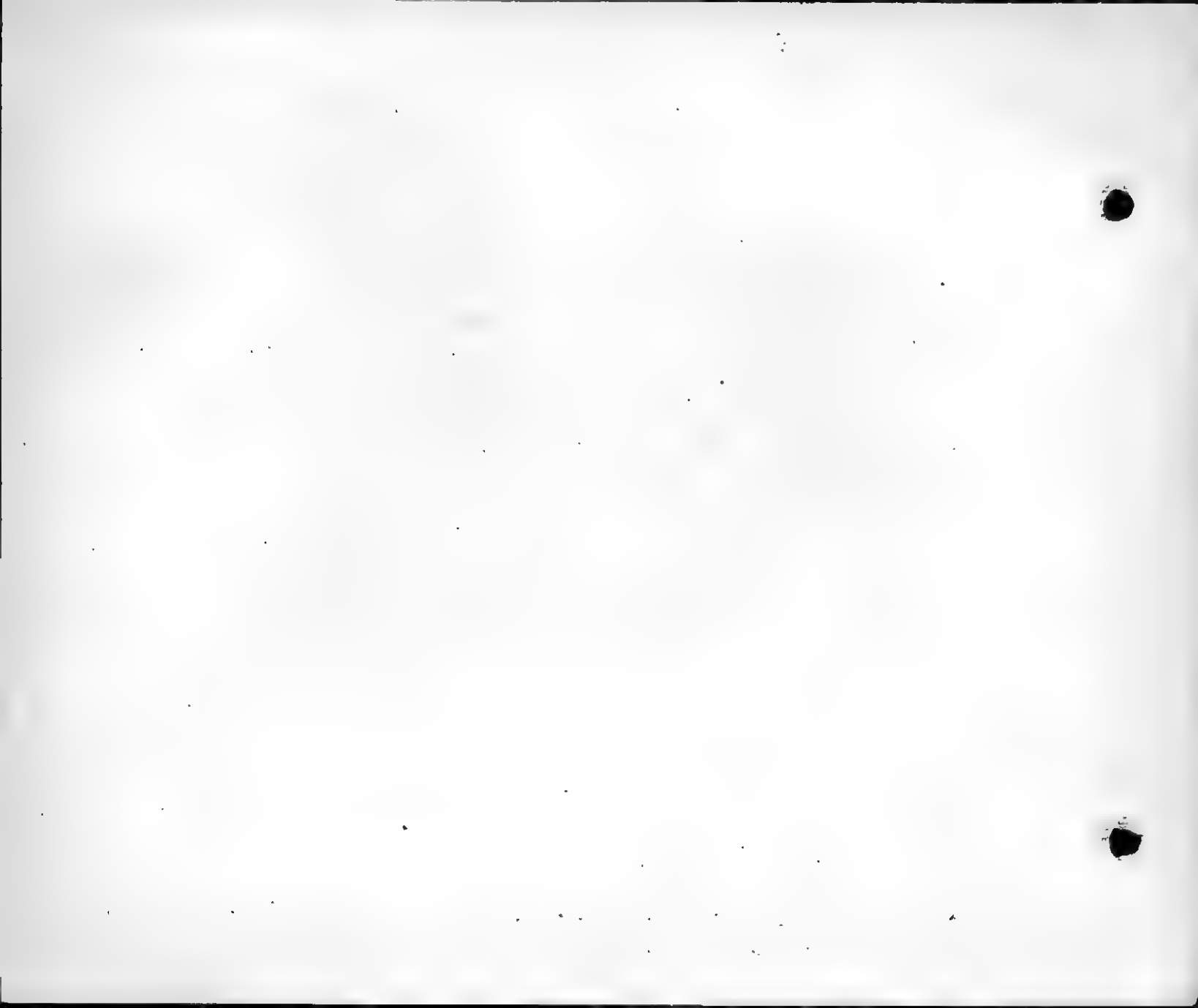
01124

CERTIFICATE OF DEATH

Reg. Dist. No. 01115

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>26yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>X Grasonville</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Subier</u> Last <u>Hunter</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1906</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Subier</u>		14. MOTHER'S MAIDEN NAME <u>Estelle P. Up</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>280-09-1504</u>	
17. INFORMANT <u>John Hunter - Grasonville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>70 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>62</u> , to <u>Jan 21</u> , 19 <u>62</u> that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>62</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin D. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Grasonville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Irvin D. Hoyt M.D.</u>		DATE SIGNED <u>1/21/62</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-25-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Grasonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shelly - Easton</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be relaxed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



01125

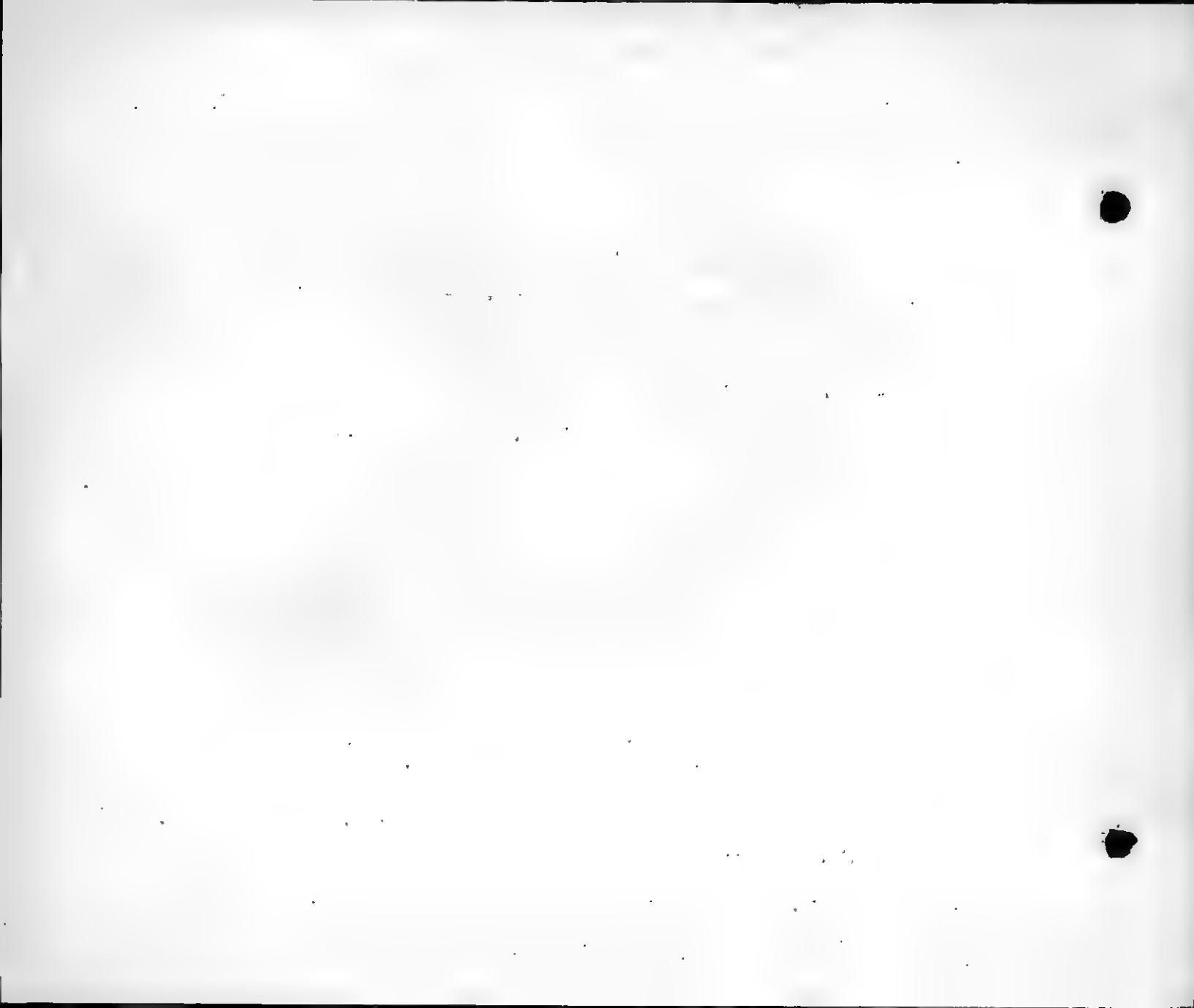
CERTIFICATE OF DEATH

Reg. Dist. No. 01116

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Church Hill</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Church Hill</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>6.</u> Last <u>Kirby</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1-1888</u>
9. AGE (In years) <u>74</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas B. Chance</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Dill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Jennie Cole--Church Hill, Md.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Atherosclerotic cardiovascular disease</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9-9</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>1-18</u> (County) <u>62</u> (State)	
21. I certify that I attended the deceased from <u>1-18</u> , 19 <u>62</u> , to <u>1-18</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>62</u> , and that death occurred at <u>7:45</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.R. Layton</u>		ADDRESS (Street, city or town, state) <u>104 S. Liberty St. 1/22/62</u>	
PHYSICIAN'S NAME (Type) <u>C.R. Layton</u>		Centreville, Maryland	
22a. BURIAL, CREMATION, REBURY, or other disposition <u>Burial</u>	22b. DATE THEREOF <u>Jan. 22</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>JAN 24 '62</u>	
ADDRESS <u>Church Hill, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>	

1

VS



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01117									
1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Price					c. LENGTH OF STAY IN 1b Price				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS Price				
3. NAME OF DECEASED (Type or print) Edward Vernon Richardson					4. DATE OF DEATH ABOUT JAN. 16 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19-1905		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME Joseph Richardson				
14. MOTHER'S MAIDEN NAME Clara Sheubrooks					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 179-07-0494				
16. SOCIAL SECURITY NO. 179-07-0494					17. INFORMANT Anthony Richardson--Price, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis Probable Conditions, if any, which gave rise to immediate cause (b) — DUE TO Body Found 10-14 day Post Death (c) Know Heavy Drinker					INTERVAL BETWEEN ONSET AND DEATH —				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Know Heavy Drinker					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Price		20g. (County) Queen Anne	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE C. R. Layton					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) C. R. Layton					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED Feb 3, 1962					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4		22c. NAME OF CEMETERY OR CREMATORY Sudlersville		22d. LOCATION (City, town, or country) Sudlersville, Md.		22e. (State) Md.	
23. FUNERAL DIRECTOR Edgar L. Kane					ADDRESS Church Hill, Md.				
24a. REC'D BY REGISTRAR FEB 6 '62					24b. REGISTRAR'S SIGNATURE Arthur L. Travis				

TO E
1.33

TENDING PHYSICIAN: The law requires that the death
retained by the hospital or

24 hours after

the funeral

~~X~~

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01127

CERTIFICATE OF DEATH

01118

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> c. LENGTH OF STAY IN b <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> d. STREET ADDRESS <u>403 Chesterfield Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Woodall Ryland</u>				4. DATE OF DEATH Month Day Year <u>JAN. 6 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 31, 1887</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE'S, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DAVIS A. Ryland</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Sheets</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-32-0306</u>			
17. INFORMANT Address <u>Mrs. Howard W. Ryland, Centreville Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary Thrombosis</u> <u>Arteriosclerotic Cardiovasculars</u> <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>13 min</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Grade 2 B Cardiac Failure</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1957</u> to <u>Jan 6, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 4, 1962</u> and that death occurred at <u>5 AM</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>C. R. Layton</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-8-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>				22d. ADDRESS <u>Centreville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 8, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crompton Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Crompton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butcher, Jr. Centreville, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 10 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Finner</u>	

MEDICAL CERTIFICATION

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FORM 15 (4)
 5M 9/60

(M)

1113

Green House

12/15/12

to 1/2

11/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

12/15/12

(1)

12/15/12